

## Centers for Medicare & Medicaid Services, HHS

## § 405.857

to a revised determination when the amount in controversy is \$100 or more.

[32 FR 18028, Dec. 16, 1967, as amended at 39 FR 12098, Apr. 3, 1974. Redesignated at 42 FR 52826, Sept. 30, 1977; 62 FR 25855, May 12, 1997]

### § 405.850 Change of ruling or legal precedent.

Change of a legal interpretation or administrative ruling upon which a determination or decision was made shall not be considered as good and sufficient reason for reopening the determination or decision.

### § 405.853 Expedited appeals process.

(a) *Conditions for use of expedited appeals process (EAP).* A party may use the EAP set forth in § 405.718 of this chapter to request court review in place of the ALJ hearing or Departmental Appeals Board (DAB) review if the following conditions are met:

(1) The carrier hearing officer has made a decision; an ALJ has made a hearing decision; or DAB review has been requested, but a final decision has not been issued.

(2) The filing entity is a party referred to in § 405.718(d) of this chapter.

(3) The party has filed a request for an ALJ hearing in accordance with § 405.855, or DAB review in accordance with 20 CFR 404.968.

(4) The amount remaining in controversy is \$1,000 or more.

(5) If there is more than one party to the hearing decision, each party concurs, in writing, with the request for an EAP.

(b) *Content of the request for EAP.* The request for an EAP:

(1) Alleges that there are no material issues of fact in dispute; and

(2) Asserts that the only factor precluding a decision favorable to the party is a statutory provision that is unconstitutional or a regulation, national coverage decision under section 1862(a)(1) of the Act, or CMS Ruling that is invalid.

[62 FR 25854, May 12, 1997]

### § 405.855 ALJ hearing.

(a) *Right to hearing.* A party to the carrier hearing has a right to a hearing before an ALJ if—

(1) The party files a written request for an ALJ hearing within 60 days after receipt of the notice of the carrier hearing decision; and

(2) The amount remaining in controversy is \$500 or more.

(b) *Place of filing hearing request.* The request for an ALJ hearing must be made in writing and filed with the carrier that issued the decision, a Social Security office, or, in the case of a qualified railroad retirement beneficiary, an office of the Railroad Retirement Board.

(c) *Effect of ALJ hearing decision.* (1) An ALJ's decision is binding on all parties to the hearing unless—

(i) The DAB reviews the ALJ decision;

(ii) The DAB does not review the ALJ decision, and the party requests judicial review;

(iii) The decision is revised by the DAB or an ALJ in accordance with the provisions of § 405.750 of this chapter; or

(iv) The expedited appeals process is used.

[62 FR 25854, May 12, 1997]

### § 405.856 Departmental Appeals Board (DAB) review.

Regulations beginning at 20 CFR 404.967 regarding SSA Appeals Council Review are applicable to DAB review of matters addressed by this subpart.

[62 FR 25854, May 12, 1997]

### § 405.857 Court review.

(a) *General rule.* To the extent authorized by sections 1869, 1876(c)(5)(B), and 1879(d) of the Act, a party to a DAB decision, or an ALJ decision if the DAB does not review the ALJ's decision, may obtain a court review if the amount remaining in controversy is \$1,000 or more. A party may obtain court review by filing a civil action in a district court of the United States in accordance with the provisions of section 205(g) of the Act. The filing procedure is set forth in 20 CFR 422.210.

(b) *Prohibition against court review of certain Part B regulations or instructions.* Under section 1869(b)(4) of the Act, a court may not review a regulation or instruction that relates to a method of payment under Part B if the regulation

## § 405.860

was promulgated, or the instruction issued, before January 1, 1981.

[62 FR 25854, May 12, 1997]

### § 405.860 Review of a national coverage determination (NCD).

(a) *General rule.* (1) An NCD is a determination by the Secretary for whether or not a particular item or service is covered nationally under title XVIII of the Act.

(2) An NCD does not include a determination of what code, if any, is assigned to a particular item or service covered under title XVIII or a determination for the amount of payment made for a particular item or service.

(3) NCDs are made under section 1862(a)(1) of the Act or other applicable provisions of the Act.

(4) An NCD is binding on all Medicare carriers, fiscal intermediaries, QIOs, HMOs, CMPs, HCPs, the Medicare Appeals Council, and ALJs.

(b) *Review by ALJ.* (1) An ALJ may not disregard, set aside, or otherwise review an NCD.

(2) An ALJ may review the facts of a particular case to determine whether an NCD applies to a specific claim for benefits and, if so, whether the NCD is applied correctly to the claim.

(c) *Review by Court.* For initial determinations and NCD challenges under section 1862(a)(1) of the Act, arising before October 1, 2002, a court's review of an NCD is limited to whether the record is incomplete or otherwise lacks adequate information to support the validity of the decision, unless the case is remanded to the Secretary to supplement the record regarding the NCD. In these cases, the court may not invalidate an NCD except upon review of the supplemental record.

[68 FR 63716, Nov. 7, 2003]

### § 405.870 Appointment of representative.

A party to an initial determination, informal review or hearing as provided in §§ 405.803 through 405.934, may appoint as his representative in any such proceeding any person qualified under § 405.871. Where the representative is an attorney, in the absence of information to the contrary, his representation that he has such authority shall be ac-

## 42 CFR Ch. IV (10–1–10 Edition)

cepted as evidence of the attorney's authority to represent a party.

### § 405.871 Qualifications of representatives.

Any individual may be appointed to act as representative in accordance with § 405.870, unless he is disqualified or suspended from acting as a representative in proceedings before the SSA or the CMS or unless otherwise prohibited by law.

[39 FR 12098, Apr. 3, 1974. Redesignated at 42 FR 52826, Sept. 30, 1977, as amended at 62 FR 25855, May 12, 1997]

### § 405.872 Authority of representatives.

A representative, appointed and qualified as provided in §§ 405.870 and 405.871, may make or give, on behalf of the party he represents, any request or notice relative to any proceeding before the carrier including review and hearing. A representative shall be entitled to present evidence and allegations as to facts and law in any proceeding affecting the party he represents and to obtain information with respect to the claim of such party to the same extent as such party. Notice to any party or any action, determination, or decision, or request to any party for the production of evidence, shall be sent to the representative of such party.

### § 405.874 Appeals of CMS or a CMS contractor.

A CMS contractor's (that is, a carrier, Fiscal Intermediary or Medicare Administrative Contractor (MAC)) determination that a provider or supplier fails to meet the requirements for Medicare billing privileges.

(a) *Denial of a provider or supplier enrollment application.* If CMS or a CMS contractor denies a provider's or supplier's enrollment application, CMS or the CMS contractor must notify the provider or supplier by certified mail. The notice must include the following:

(1) The reason for the denial in sufficient detail to allow the provider or supplier to understand the nature of its deficiencies.

(2) The right to appeal in accordance with part 498 of this chapter.

(3) The address to which the written appeal must be mailed.